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## PROFESSIONALISM

# Professionalism in UK paramedic practice

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This paper explores the influences on professional behaviours in UK paramedic practice.

In 1998 the DH launched the concept of clinical governance in its policy *"A First Class Service: Quality in the new NHS"*. This included the following statement:

> *"Patients & their families place their trust in health professionals. They need to be assured that their treatment is up to date & effective & is provided by those whose skills have kept pace with new thinking and new techniques"*[1]

Clinical governance has been defined as:

> *"A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"*[2]

The principles of clinical governance include:

- Patient-centeredness
- Shared evidence-based standards
- Individual and organisational accountability
- Systematic learning from untoward incidents
- Mechanisms for continuous quality improvement
- Strong leadership
- Organisational, professional and occupation cultures that value excellence

Clearly, these overlap considerably with the features of a profession, and as such, clinical governance offers a framework for professional practice. To achieve these aims, its practice includes a number of components.

Risk management requires the assessment of risk, in terms of its likelihood of occurring and the magnitude of any impact arising from a lack of adequate remediation, with the ultimate aim of prevention or risk minimisation. A key component is the establishment of an organisational learning culture – this requires that all adverse incidents and 'near misses' are

reported so that the ambulance service and its professionals can implement strategies to prevent a repetition. This requires the recognition that systems are the most common cause of errors, and that since humans are fallible it is essential that these systems are designed accordingly. These lessons need to be communicated effectively both within an organisation and throughout a profession and other interested organisations to maximise the learning opportunity. It is often argued that reliable error reporting requires the adoption of a 'no-blame' culture. Whilst this true for genuine errors, if a practitioner consciously and deliberately fails to follow established guidelines and policies designed to prevent mistakes, then clearly they must be held accountable.

Information management is another component of clinical governance. In addition to managing the process of performance reporting, the key role is to manage patient identifiable data so that confidentiality is maintained at all times. In addition, UK law requires that such data be only used for the purpose for which it was gathered – anything else requires the patients' informed consent.

Undertaking research and managing its conduct so that it falls within legal and culturally agreed standards is an essential part of clinical governance, as its application to practice – sometimes know as clinical effectiveness. Developing and applying a discrete body of knowledge through research and scholarship is widely agreed component of what it is to be a profession.

The boundary between research and clinical audit is often blurred, but one component of the latter is to confirm through the observation of practice and records that health workers are complying with standards of care (guidelines or protocols). However, an equally important but often overlooked aspect of audit is the confirmation that compliance with guidelines is having the anticipated beneficial impact on patient outcomes.

Education is the means by which the recommendations, lessons and policies arising from risk management, research, and audit are implemented into clinical practice. Importantly, successfully obtaining a qualification after an initial training course is no longer considered to be sufficient to guarantee high quality practice throughout the many years of a practitioner's career. Consequently, continuous professional development (CPD) is increasingly becoming a mandatory requirement of health care workers.[3] In the UK, all paramedics must be registered with the Health Professions Council (HPC): it is against the law to use this title (alone or in combination with other words) or for anyone (including the National Health Service) to employ a practitioner in this role who is not registered. Paramedics must re-register every three years, and during this interval are required to have undertaken CPD and retained appropriate evidence of having done so.4 This principle of life-long learning requires that practitioners learn and *unlearn* faster and more effectively in order to develop within their current scope of practice, understand their role and its relationship with other health professionals, and to change their scope of professional practice. It has been said that life-long learning helps patients to be confident that:

*"Service development, skills and knowledge of those providing the care & treatment are keeping pace with change"*[1]

In the UK, it is government policy that health professionals assume the responsibility for self-regulation:

"*Health care professionals..set their own standard of professional practice, conduct and discipline"*[1]

Self-regulation is about assuring people of one's *professional* abilities and conduct. Professional bodies – for UK ambulance personnel, the College of Paramedics (equivalent to ACAP in Australasia) – either establish or consult on the development of these standards by registrant bodies (the HPC). Put simply, the professional bodies set the standards, and the registrant bodies enforce them.
The College of Paramedics (the professional body) has the role of agreeing / developing standards for regulation by the Health Professions Council (HPC):

- Standard of conduct, performance and ethics
- Standards of proficiency
- Standards of continuous professional development
- Standards of education and training (Curriculum Framework)
- Standards for entry to standard and specialist practice
- Clinical guidelines (in the UK these are developed by the Joint Royal Colleges Ambulance Liaison Committee, with significant input from the paramedic profession)
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The Health Professions Council (the registrant body) has the role of protecting the public through enforcement, relying on the input of both the public and professionals:

- Maintaining a register
- Receiving and investigating complaints
- Determine the need for / implement disciplinary action
- Accreditation of educational facilities and programmes
- Reciprocal registration

Registration of paramedics has the over-riding aim of protecting the public from unprofessional practitioners. It makes each paramedic accountable for their own actions *and* those of other health care practitioners that they work with - regardless of their rank or profession. They have an absolute duty to report poor practice (by their colleagues and other health professionals) – or they risk sanctions against themselves by the HPC (because they are thereby failing to protect the public).

Anyone can report a paramedic to the HPC for alleged misconduct of any nature. As mentioned, fellow paramedics have a duty to do so, but employers arguably have a legal obligation to do so (and certainly could be held accountable for any harm caused by not doing so under civil law). Other health professionals and the public may also report concerns, and these may be about poor standards of clinical practice, unprofessional behaviour, criminal acts (regardless of whether these have occurred during working hours), and ill health sufficient to prevent the safe and effective practice.[5] Ideally, the paramedic concerned should report any of the above issues themselves, as this reflects professional behaviour.

Once an allegation is made, the HPC will arrange for it to be reviewed by paramedics, other allied health professionals, and, most importantly, members of the public, to determine if there is a case to be answered. If it is determined that there is then a hearing will be held to review the evidence in detail which the paramedic will be invited to attend. Should they be found at fault, the HPC can apply a number of sanctions:

- Caution – this is documented against the paramedic's name on the register that is open to public scrutiny for a defined time

- Conditions of practice – documented as above and, for example, requiring that a proscribed course of training is successfully completed or that the individual only works with another paramedic for a period of time
- Suspension - documented as above and for a defined period of time.
- Striking off – removal of the right to practice as a paramedic or to identify oneself by this title

Details of pending and completed hearings can be reviewed on the HPC's website at http://www.hpcuk.org/complaints/hearings/index.asp?showAll=1&professionID=10&Surname=&Submit=Search .These make salutary reading and have considerable educational value.
It should be remembered, however, that paramedics, in common with all health care professionals, are exposed to the risk of sanctions from a number of other sources. In the UK, employers may discipline a paramedic for an act they feel to be inappropriate regardless of whether the HCP decides to do so. Employment law permits verbal warnings, written warnings, and final written warnings to be applied, or for dismissal. If an appeal is made to an Employment Tribunal (an independent statutory body in law) their interest will be to confirm that the employer has a disciplinary procedure in place and that it has acted in accordance with this – it will not concern itself with the 'rights or wrongs' of the decision itself. The system of criminal law will be enforced in the event of, for example, fraud or assault, and all health workers are familiar with the risk of being sued under civil law. It is important to understand that the standards of proof required vary depending on the institution considering an allegation. Criminal law requires 'proof beyond reasonable doubt' whereas the standard of proof required by employment and civil law and the registrant body is 'the balance of probabilities'. This determines whether the action was more or less likely to have occurred.

A number of tensions arise between these various strands of regulation of paramedic conduct. The HPC expects paramedics to practice within their competence – but applies *minimum* but not maximum standards. Employers, however, may legally instruct their employees to restrict their practice – even if this is to a level below that generally agreed to be the minimum standard. As a result, it is then possible for a patient or relative to sue the employer for restricting the paramedics practice – if they sue the paramedic, under UK law if they are following their employers policies and procedures, the employer is vicariously liable. Finally, a patient or relative may sue a paramedic for doing the *right* thing – although (hopefully) they are unlikely to win the case in court. The best advice I have been offered to 'stay out of trouble' is that although both *good* and *bad* paramedics can get sued, *nice* paramedics don't get sued. This is certainly supported by a read through the cases described on the HPC website – by far the majority relate to instances of poor attitudinal behaviours, and those most likely to lead to the individual being struck off the register – the most severe sanction - relate to criminal acts.

Registered paramedics are responsible for reassuring the public and their colleagues of their clinical competence through undertaking a number of activities. These include having an effective registration with a professional body; self and peer review and reflective practice; personal development planning; taking part in clinical supervision, benchmarking, action learning, continuous professional development, and audit activities; reading professional journals regularly (and critically); networking with other health professionals; role modelling for junior colleagues and acting as a mentor and preceptor; and by contributing to standards-setting for clinical guidelines, curriculum frameworks, conduct, performance, and ethics, and competence and proficiency and consultation opportunities of relevance to professional practice.

Teaching professionalism is about changing knowledge, skills, and attitudes. Professionalism in action is also a cultural issue, consisting of collective as well as personal beliefs, attitudes, and inter-personal behaviours. Clearly these are difficult to influence through traditional classroom based educational activities. However, when asked what differentiates them from paramedics trained through vocational routes, graduate paramedics identify that they have been '*taught to think independently*', but that vocationally trained paramedics are taught '*only what they must know*'. It has been suggested that thinking is the most powerful way of changing beliefs and therefore attitudes.

Professionalism can perhaps best be demonstrated by the example of others and assessed in situ during practice. Any job is taught to some degree by learning from others, sometimes know as 'sitting next to Nellie'. Clearly employers should be careful which 'Nellie' their staff sit next to, as culturally-embedded 'bad' attitudes are equally likely to be acquired in the way, and so excellent role models should be selected to work as mentors and preceptors. In order to ensure that the full range of behaviours are witnessed and that opportunities are made available to discuss beliefs and attitudes in the widest range of circumstances, clinical supervision must take place in real-world settings by working with professionals in practice and supporting reflection in a timely manner.

So are paramedics professionals, either in the UK or in Australia? Although there are a number of features that have been described as being essential to being a profession, in reality it is the perception of us as a group by others whose opinions we value that really counts, such as physician, nurses, and other allied health professions. Of course the standards of entry to our profession, the academic levels we must attain and maintain to practice, our clinical scope, and our ability to research and educate ourselves independently will all figure within such evaluations. However, above and beyond anything else it is how our collective behaviour and beliefs are viewed externally which will determine whether we are seen as being a profession. Or not...

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